Clinician's Commentary on Duncan et al.¹

The Regulated Health Professions Act, which permits physical therapists to be primary contact professionals, has been adopted by most Canadian provinces, but because it applies only to physical therapists in private practice, in many provinces a physician's referral is still required before initiation of physical therapy in hospitals. Opponents of direct access to physical therapy (PT) argue that physical therapists may overlook serious medical conditions. In the acute-care setting, however, physical therapists are considered essential members of the inter-professional health care team. Physical therapists working in critical care have the knowledge and experience to relate medical stability and PT practice, which gives them a basis for initiating PT service as soon as appropriate.

Numerous studies have documented the effect of early implementation of PT interventions in preventing sequelae of immobility.^{2–5} There is growing evidence that early mobilization of patients in the intensive care unit (ICU) is a safe and cost-effective strategy to improve patient outcomes.^{6–11} In ICUs where early mobilization is not part of usual care, its adoption requires a change in philosophy by the multidisciplinary team, including physical therapists, registered nurses, respiratory therapists, and physicians. Harris and colleagues¹² have described a physical therapist-led programme to introduce such changes in a 16-bed medical-surgical and a 15-bed cardiovascular ICU. The process began with multidisciplinary meetings and education sessions to inform the critical-care team about the effect and safety of early mobilization. A lead physical therapist advocated early mobility and developed both solutions to overcome the identified barriers and guidelines for implementing PT services. With the initiation of this programme, the number of ICU patients receiving PT evaluations and treatment increased from 364 in 2011/2012 to 542 in 2012/2013.¹²

Jette and colleagues¹³ investigated the ability of physical therapists to practise safely—specifically, to make decisions about patient management—in direct-access environments. A survey was sent out to a random sample of 1,000 members of the Private Practice Section of the American Physical Therapy Association, 390 of whom agreed to participate in the study. The survey presented 12 hypothetical case scenarios and asked respondents to state whether, in each case, they would (1) provide intervention without referral, (2) provide intervention and refer, or (3) refer before intervention. On average, the respondents—physical therapists with an orthopaedic specialization—made the correct decision 87% of the time in musculoskeletal cases and 88% and 79% of the time, respectively, for non-critical and critical medical conditions. The odds ratios for making 100% correct decisions were 2.23 (95% CI, 1.35–3.71) for musculoskeletal conditions and 1.89 (95% CI, 1.14–3.15) for critical medical conditions.

Duncan and colleagues conducted a chart review to investigate how implementing PT self-referral in the medical-surgical neurological intensive care unit (MSNICU) of the Toronto Western Hospital affected time to access of PT service and referral volume.¹ They found that while day-to-day caseloads remained largely unchanged, the number of patients treated by physical therapists increased as a result of daily screening and the use of PT self-referral to capture patients who might previously have

been missed. The most important findings of Duncan and colleagues' study were that PT self-referral resulted in more timely access to PT services and that for medically stable patients, it reduced the delay between admission to MSNICU and initiation of PT.¹

This shorter delay between admission and PT initiation is critically important: the sooner PT assessment and treatment can be initiated, the better for the patient's overall treatment, which can lead to shorter ICU and hospital stays and perhaps even cost savings for our health care system.

As an intensive-care physical therapist, I was fortunate to work in an ICU where physical therapists had blanket referrals and could evaluate patients for treatment within the first day after admission. The results of the studies cited here, including that of Duncan and colleagues,¹ confirm physical therapists' capacity to be primary contact professionals and the efficacy of early intervention. I would advocate for the acceptance of this practice and/or blanket referrals throughout hospitals in Canada.

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